BREAST ASSESSMENT REQUEST FORM

Please complete all sections and fax to 519-646-6204

St. Joseph's use: Exam date: _____

1. PATIENT INFORMATION – *please affix label or complete:*

Last Name: _____

First Name: _____ Middle initial: ___

Gender: _____ Date of Birth: _____/_____/_____
Day Month Year

Health Card No.: _____ VC: _____

Address: _____

City: _____ Postal Code: _____

Telephone (day): _____ (evening): _____

Email: _____

Mobility: ☐ Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Mechanical Lift

Interpreter required? ☐ No ☐ Yes, language: _____

2. REFERRING PHYSICIAN INFORMATION

Referring Physician Name: _____

Address: _____

City: _____ Postal Code: _____

Billing No.: _____

Phone: _____

Fax: _____

Family Physician: _____

****Patients ≥ 50 and <75 years with no previous breast cancer: patient call St. Joseph's OBSP at (519) 646-6105 to book****

3. PREVIOUS IMAGING? ☐ No ☐ Yes When? Where? _____

** Please attach breast imaging reports NOT generated at St. Joseph's*

4. REASON FOR REFERRAL

Does the patient have breast implants? ☐ No ☐ Yes

If yes, indicate type: ☐ Silicone ☐ Saline

Appointment for:

☐ **SCREENING**

☐ **BI-RADS 3**

☐ **DIAGNOSTIC**

☐ New Clinical Concern ☐ No ☐ Yes

If yes, please describe: _____

_____

_____

5. HISTORY/CLINICAL FINDINGS (required):

☐ Palpable lump ☐ Right ☐ Left

Lump detected by: ☐ Patient ☐ Physician

☐ Pain ☐ Right ☐ Left

☐ Focal ☐ Diffuse ☐ Intermittent

☐ Nipple Discharge ☐ Right ☐ Left
(only if spontaneous,non-milky)

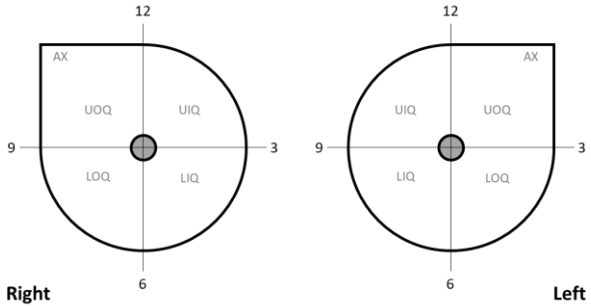
Type of discharge ☐ Bloody ☐ Other:

History/Findings: _____

_____

_____

6. ***Please indicate all clinical concerns on diagram***



SCREENING BREAST ULTRASOUND IS NOT ROUTINELY PERFORMED AT ST. JOSEPHS HEALTH CARE LONDON

7. NOTE: By Signing this requisition, you are providing authorization to St. Joseph's for your patient to receive additional imaging and urgent surgical consultation, as required, to resolve this diagnostic request.

8. Physician signature: _____

Revised: May 2024